MARKET CONDUCT EXAMINATION

OF

FIRST CHOICE HEALTH PLAN

601 UNION STREET, SUITE 1100
SEATTLE, WA 98101

July 1, 1999 – November 30, 2000

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January 25, 2002

The Honorable Mike Kreidler
Washington State Insurance Commissioner
Insurance Building
P.O. Box 40255
Olympia, Washington 98504

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

First Choice Health Plan, NAIC #47046
601 Union Street, Suite 1100
Seattle, Washington 98101

This report of examination is respectfully submitted.

This was a limited scope examination of the companies' activities between July 1, 1999 and November 30, 2000.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of the Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Barnes, AIE, ACS and George J. Lazur, AIE, CPCU of the Washington State Office of the Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of First Choice Health Plan during the course of this market conduct examination.

I certify that the following is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of the Insurance Commissioner, and that this report is true and correct to the best of my knowledge and belief.

_____

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This market conduct examination report is by exception and additional practices, procedures, and files subject to review during the examination were omitted from the report if no improprieties were indicated. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code. In this report, First Choice Health Plan is referred to as "First Choice", "FCHP" or "the Company".

Scope

Time Frame

The examination covered the company's operations from July 1, 1999 through November 30, 2000. This was the first examination of First Choice Health Plan and was performed in the OIC's Seattle office and on-site at the company's home office in Seattle, Washington.

Matters Examined

The examination included a review of the following areas:

Advertising	Complaints
Claims	Underwriting
Agent Activity	Sales Activity
Rates and Contract Administration	Provider Contracting and Relations

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

These are the guidelines prescribed by the National Association of Insurance Commissioners in the Market Conduct Examiners Handbook.

Regulatory Standards

Samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as "met." The standard in the area of agent licensing and appointment will not be met if any

violation is identified. The standard in the area of filed rates and forms will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

COMPANY OPERATIONS AND MANAGEMENT

First Choice Health Plan (FCHP) was incorporated on December 21, 1994, as a spin-off of First Choice Health Network (FCHN). FCHP was admitted as a Health Care Service Contractor (HCSC) in Washington State on January 13, 1995. In 1996, FCHP began offering pre-paid group health care plans. In July 1997, the Company merged two similar small health plan companies, Sound Health and Health First Partners, into FCHP.

The Company maintains two locations in Seattle, Washington. Its main office located at 601 Union Street, Suite 1100, Seattle, Washington, houses customer service, claims processing, computer support, premium billing and enrollment, accounting, and administrative services. Its location at the Metropolitan West Building in Seattle houses the Company's provider contracting and marketing departments.

First Choice Health Plan is owned by four (4) entities. First Choice Health Network is the majority owner. The other owners are Washington Health Care Alliance, LLC, MultiCare Health System and Swedish Health Services.

A 15 member Board of Directors governs the management and control of the Company. Board members are elected to three-year terms. Elections are held at the annual shareholder meeting each June. No limit exists on the number of terms a Director may serve. The following chart lists the Board members at the time of the examination:

Board Member	Principal Affiliation	Term Expires
Barbara Louise Mauk, Chairperson of the Board	Human Resources Director, Valley Medical Center	2003
Robert Dean Martz, MD	Neurosurgery Associates of Spokane	2002
Paul Michael Elliott	Business Consultant	2002
Andrew George Fallat	CEO, Evergreen Healthcare	2004
William James MacDonald, MD	President, The Everett Clinic	2003
Kenneth Douglas Graham	President & CEO, Overlake Hospital Medical Center	2003
Phillip Jeffrey Haas	Primary & Managed Care Administrator, Valley Medical Center	2002
Richard Alan McGee, MD, FACP	President, Puget Sound Cancer Center	2003
Richard Harold Peterson	President & CEO, Swedish Health Services	2004
Garman Ernest Lutz	Senior Vice President of Finance, Empire Health Services	2004
Clyde Darryl Walker	First Choice Health Network Compensation Committee	2004
William Frederick Johnston, MD	Emergency Services Medical Director, Northwest Hospital	2004

Board Member	Principal Affiliation	Term Expires
William Richard Stubbs, MD, MBA	Vice President of Medical Affairs, MultiCare Health System	2002
Diane Elaine Cecchettini, RN	President & CEO, MultiCare Health System	2004
Nancy Jane Auer, MD	Vice President of Medical Affairs, Swedish Medical Center	2003

The principal officers of the Company are:

Name	Office
Gary Robertson Gannaway	President & CEO
Barbara Louise Mauk	Secretary
Kenneth Andrew Hamm	Treasurer

Territory of Operations

First Choice Health Plan operates in the following counties in Washington State: King, Lewis, Mason, Pierce, Snohomish, Thurston, Adams, Lincoln, Spokane, Stevens and Whitman. The Company also operates in the following counties in Idaho: Benewah, Bonner, Boundary, Kootenai, Latah, and Shoshone. The examiners found no evidence of the Company operating outside of the above stated counties.

Findings

The Company operations and management portion of the examination is designed to provide a view of the Company structure and operations. This section of the report is not based on sampling techniques.

The Company passed the following Operations/Management Standards without comment:

Standard	Reference
Operations/Management Standard #1: The Company is required to be registered with the Office of the Insurance Commissioner prior to acting as a health care service contractor in the State of Washington	RCW 48.44.015(1)
Operations/Management Standard #2: The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and amendments at the same time as submitting such documents to the Secretary of State.	RCW 48.44.013

ADVERTISING

The Company provided a copy of its advertising file to the examiners. The file contained 130 items. The examiners determined that the advertising file was complete. In addition to the hard copies provided, the examiners reviewed the Company's internet web pages. The advertising file did include copies of the web pages with notations and edits of the final pages.

Findings

The following exceptions were noted:

Advertising Standard #1: The Company's advertising materials are published in accordance with all Washington Advertising Regulations. Reference: WAC 284-50-010 through 230, RCW 48.30.040 through RCW 48.30.090, and RCW 48.44.110.

Findings: Passed with comment. 99.2% compliance.

One (1) advertising item of the 130 items reviewed contained statistical references without disclosing the source of the statistics, violating WAC 284-50-110(3):

- Radio spot used to introduce KIXI's "Voices of Experience" program.

Subsequent Event: Effective April 2001, FCHP revised policies and procedures to require a reference to the source of statistics when using statistical data.

COMPLAINTS

Procedures

First Choice Health Plan provided the OIC with a copy of the Appeals and Grievances Procedures, revision September 2000. The procedures are extensive and very detailed. There are eight (8) levels in the appeals and grievance process. The procedures include definitions of all levels of the process and accurately describe the process.

General Complaints

The Company provided the examiners with a copy of its database for Appeals and Grievances. During the examination period, 414 appeals and grievances were logged into the Company's Appeals and Grievance database. The examiners selected a random sample of 50 files for review. Four (4) files involved self-insured plans and one (1) involved a federal plan. These appeals and grievances were removed from the sample because they fall outside the scope of this examination. This left 45 files that were reviewed by the examiners.

The following chart lists the reasons and dispositions of the 45 appeals and grievance files:

Type	Number	Overturned	Upheld	No Decision
Benefits	2	1	1	0
Claim Handling	14	11	3	0
Network Adequacy	2	2	0	0
PCP Assignment	3	3	0	0
Preauthorization	16	10	5	1
Quality of Care	1	0	0	1
Referrals	7	4	3	0
Totals	**45**	**31**	**12**	**2**

More than half of the general appeals and grievances involved preauthorization and referral. Many of these appeals and grievances involved decisions made at the provider organization level. Company personnel told the examiners that "the need for clarification of the benefits available to our membership was ongoing." As discussed in detail in the report section Contracts and Member Handbooks, the member handbook language inferred that the member's PCP had final say in all treatment plans. The members assumed based on this language that if the PCP directed treatment it would be allowed and they would schedule and receive treatment based on their PCP direction. The actual sequence of events was for the referral/preauthorization to go to the medical management unit at a provider organization and that entity would approve or deny the treatment, often after treatment had been given. When payment was denied, the member would file an appeal or grievance with FCHP. If FCHP found that the member was misinformed or misled in the process, FCHP would "pay and educate". However, this does not change the fact that this was an ongoing problem during the examination period which was not addressed by FCHP.

Subsequent Event: As of January 2001, there was only one (1) provider organization that continues to do referrals and preauthorizations. These functions are performed by FCHP for all other members. Bi-monthly meetings are held with this provider organization to ensure that they are working within the parameters established by FCHP.

The examiners noted a significant increase in the number of appeals and grievances beginning March 2000. Company personnel attribute two factors to the increase:

- FCHP cites the effective date of WAC 284-43-620 as contributing to the increase in appeals and grievances experienced by the Company. WAC 284-43-620, which was effective December 31, 1999, defines procedures for review and appeal of adverse determinations. Amendments with the detailed information concerning a member's right to appeal decisions made by the Company were sent to all members coincident with the effective date. FCHP's position is that the distribution of the amendment announcing the new health care service review procedures educated their members about the process of filing complaints with the Company.

- Prior to February 2000, FCHP's mailroom distributed all complaints directly to the affected departments for handling and resolution. If the mailroom staff were unclear, the complaint

was routed to the Member Services Supervisor or Correspondence Representative for appropriate review and handling. This distribution method did not effectively capture complaints for appropriate routing and tracking. Additionally, the Appeals and Grievances Department consisted of one employee. Appeals and grievances were routed directly to the employee and only those appeals and grievances received in the department were tracked.

In February 2000, procedures were revised and all complaints, appeals and grievances are routed directly to the Appeals and Grievances Department. Implementation of this procedural change provides prompt routing and accurate tracking of complaints, appeals and grievances from receipt to resolution. FCHP added additional staff to accommodate the change in procedures.

The examiners noted significant delays, averaging 30 working days, for mail distribution from the Company's mailroom to the Appeals and Grievance Department during the first three (3) months of the examination period. The Company responded that complaints were either misrouted or not distributed appropriately from the mailroom. The Company implemented training and re-education of the mailroom staff. These quality improvement initiatives have significantly improved the delivery time of mail within the Company. The date stamps on the remaining files in the sample show no more than a two (2) working day lag from receipt in the mailroom to receipt by the Appeals and Grievances Department.

OIC Complaints

During the examination period, the OIC received 62 complaints about FCHP. Two (2) of these complaints were not forwarded to the Company, and twelve (12) were complaints concerning self-funded plans. The remaining 48 complaints were reviewed by the examiners.

The reasons and dispositions of the 48 complaints are broken down as follows:

Type	Number	Overturned	Upheld	No Decision
Benefits	8	5	2	1
Claim Handling	15	12	3	0
Eligibility	6	1	3	2
PCP Assignment	2	1	0	1
Preauthorization	4	4	0	0
Premium	1	0	0	1
Provider	1	1	0	0
Provider Contract Rules	2	0	1	1
Quality of Care	1	0	0	1
Referrals	8	7	1	0
Totals	**48**	**31**	**10**	**7**

Findings

The Company passed the following Complaint Standards without comment:

Standard	Reference
Complaint Standard #1: The Company has filed a copy of its procedure for review and adjudication of complaints with the OIC.	RCW 48.43.055
Complaint Standard #2: The Company has a means to disclose to an enrollee or prospective enrollee a copy of the grievance procedures for claims and for service denials as well as dissatisfaction with care.	RCW 48.43.095(1)(h)

The following exceptions were noted:

Complaint Standard #3: The Company complies with procedures for health care service review decisions. Effective December 30, 1999. Reference: WAC 284-43-620.

Findings: Failed. 94.3% compliance. See Appendix I.

Thirty-five (35) of the 45 files in the general complaint sample were received after the effective date of WAC 284-43-620, which defines procedures for the review and appeal of adverse determinations made by the Company. Of these 35 files, two (2) were not responded to within 14 days as required by WAC 284-43-620(1). One (1) file was responded to in 36 days; one (1) file was responded to in 85 days.

Complaint Standard #4: Response to communication from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested in the original communication. Reference: WAC 284-30-650, Technical Advisory T98-4.

Findings: Passed with comment. 95.8% compliance. See Appendix II.

The examiners reviewed the OIC complaints to determine the length of time from receipt to response to the OIC. The average response time to the OIC was 12.1 days from receipt. In two (2) files that were reviewed, the Company failed to respond to the OIC within 15 business days of receipt of the complaint. These two (2) files are in violation of WAC 284-30-650.

AGENT ACTIVITY

During the examination period, 253 licensed and appointed agents represented the Company. Of these agents, eleven (11) are employees of FCHP. Information provided by the Company is consistent with records maintained by the OIC.

Licensing and appointment of agents is the responsibility of the Compliance Department. The Company provided the examiners with policies and procedures for agent appointment. The procedures are clear and concise in regard to compliance with Washington licensing and appointment statutes.

The examiners reviewed a total of 132 agents for this section of the examination. Eleven (11) of these agents are Company marketing personnel and the remaining 121 were randomly selected as part of the Sales Activity – New Business/Quotes section of the examination. The agent licensing and appointment dates for the marketing personnel were compared to their dates of hire and dates that their marketing positions began. For the agents selected as part of the New Business/Quote sample, the agent licensing dates and appointment dates were compared to the dates new business or renewal quotes were provided to the agent. The files reviewed consisted of the following:

Source	Total Files	Number Examined
Inforce Business	6,804	67
Quotes	20,219	54
Marketing Personnel	11	11
Total	**27,034**	**132**

Findings

The Company passed the following Agent Activity Standard without comment:

Standard	Reference
Agent Activity Standard #2: The Company requires that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.	RCW 48.17.010

The following exceptions were noted:

Agent Activity Standard #1: The Company ensures that agents are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.44.011, RCW 48.17.060(1) and (2).

Findings: Failed. 97.7% compliance. See Appendix III.

The review of these files resulted in the following:

- One (1) agent that was not licensed or appointed at the time of sale is shown as the writing agent on one (1) new business cases.
- Two (2) agents that were not licensed were issued quotes.

SALES ACTIVITY – NEW BUSINESS/QUOTES

FCHP's product line consists of the following plans: Managed Care, Point of Service, and Triple Option. The majority of its business consists of Costco and Association plans.

The examiners randomly selected a sample of quotes to review from the Company's quote logs and inforce group files. During the examination period, 22,517 quotes were issued to new groups, and 6,804 inforce group quotes were issued. From these, the examiners selected 177 for review.

In the review, the examiners looked at the following:

- Review rates charged and quoted to groups to ensure that the rates and factors filed were used to determine premium.
- Review the file to ensure that the benefits requested were the benefits quoted and/or sold.
- Review agents to ensure that the agent requesting the quote was properly licensed and appointed (see section on Agent Activity for violations).
- Review Account Executive information to ensure that the AE working on the quote was properly licensed and appointed (see section on Agent Activity for violations).

Findings

The following exceptions were noted:

Sales Activity Standard #1: Rates and benefits have been filed with the Office of the Insurance Commissioner. Reference: RCW 48.44.040, WAC 284-43-920(1).

Findings: Failed. 89.8% compliance. See Appendix IV.

The Company provided the examiners with copies of its rate filings for the examination period. These filings were compared to the OIC records in order to verify that all rates had been filed.

The 2000 rates for large and small groups were filed with the OIC on December 20, 1999 for an effective date of January 1, 2000. The OIC did not approve the filing initially as there were missing pieces of information. One of these missing pieces was the table showing the demographic factors to be used in rate calculations. FCHP answered the OIC's questions about the filings stating that there were no changes in these factors, but did not submit the actual table showing the factors. Subsequently, the OIC approved the filing on March 27, 2000.

Discussions with the Company indicate that omission of the table was inadvertent and unintentional. The Company does understand that any future filings must contain the actual table showing the factors, even if those factors have not changed from the previous filing. The examiners looked at the 2001 filings and they appear to be complete.

The examiners also noted errors in the small group prescription drug filings. FCHP states that these were typographical errors. The examiners noted that the trending was stated to be 1.5% per quarter and calculated at 1.5% per quarter for 1999. The 2000 filing shows the 1999 rates were actually trended at 3.75%. The rates for 2000 state that the trending will be 4.25% per quarter. When the actual calculations are performed, the trending is 4.75% per quarter. The examiners confirmed that FCHP used the following percentages in its rating model software:

- 1999 – 3.75%
- 2000 – 4.75%

The examiners noted 18 errors out of 177 quotes reviewed. The disposition of those quotes with errors is as follows:

Rate Overcharge	Rate Undercharge	Unfiled Negotiated Groups
6	5	7

- Six (6) groups in the sample were charged rates that were higher than those filed. Two (2) involved COBRA segments of a negotiated group whereby the rates included a 4.14% surcharge, rather than the allowable 2 percent. The overcharge totals $3,129.79.

Subsequent Event: The Company has agreed that refunds are due all groups affected by using the unfiled surcharge, and have agreed to refund the appropriate amounts by April 30, 2002.

- Five (5) groups in the sample were undercharged for 2000. The undercharge totals $17,289.85. The examiners reviewed the 2001 rates charged to these groups and found the groups are being charged the correct amounts.

- Seven (7) of the groups in the sample used unfiled rates. Six (6) of these groups were negotiated filings, and one (1) concerned a conversion plan. The Company has been instructed to file the negotiated rates and benefits for the six (6) groups cited, and to file current benefits and rates for its conversion plans.

Subsequent Event: As instructed by the OIC, FCHP filed the negotiated rates in October and November 2001. The conversion plan was filed in July 2001.

CONTRACTS AND MEMBER HANDBOOKS

The Company issued small and large group contracts during the examination period. For these group plans, a complete contract is comprised of:

- Certificate of Coverage
- Group Medical Services Agreement (GMSA)
- Member Handbooks
- Benefits Summary

- Any specific riders included with the plan (i.e., chiropractic, dental, vision, etc.)

FCHP writes three plan designs: managed care, point of service and triple option. The managed care plan restricts coverage to a community network or provider organization unless the primary care provider or the Company authorizes other treatment. The point of service plan allows the use of an extended network of participating providers without a referral, but at a lower benefit level than the network level. The triple option plan adds the use of non-participating providers at a lower level of benefits than the point of service plan.

During review of the appeals and grievances procedures the examiners noted that there were a large number of appeals because the referral and preauthorization process was unclear in certificates of coverage and member materials in use by FCHP during 1999. The member materials stated that care is to be coordinated through the member's PCP. The certificates of coverage stated that certain services require referral authorization in order to be covered. Confusion came about because the two sets of material did not contain the same language and the members referred to their materials rather than the certificate of coverage when seeking treatment. Since their materials do not mention that the PCP must send referral and preauthorization requests to the provider organization medical management unit for approval prior to treatment, the members assumed that their PCP's recommendation was all that was needed. Because of the ambiguous language, FCHP paid those claims denied for lack of referral or authorization when the member could show that they did not understand the process. This action increased the claim liability for the company.

Changes to the contract language were made in some materials in 1999 and the balance were changed in 2000. As the documents are organized now, information concerning the procedures for referrals and preauthorization is located in two separate locations – the section titled Choosing a Primary Care Provider and the section titled Referral Authorization Requirements. The examiners do note that ongoing modifications to language describing the preauthorization and referral process have been made in the certificates of coverage and member materials.

Subsequent Event: The Company is discontinuing the use of member handbooks in 2001, subsequent to the examination period. In lieu of a handbook, members receive a package containing a Certificate of Coverage that mirrors the GMSA, a benefit summary for their plan, including riders and an "Easy Reference Guide" brochure.

Findings

The Company provided the examiners with 230 member contract forms and riders in effect for the examination period. All of the forms were filed with and approved by the OIC. All of the forms were reviewed.

The following exceptions were noted:

Contracts and Member Handbooks Standard #1: All contracts must contain mandated benefit provisions and conform to prescribed format standards. Reference Chapters 48.43 and 48.44 RCW, and Chapters 284-43, 284-44, 284-51, 284-52, and 284-53 WAC.

Findings: Failed.

- RCW 48.44.342 requires that contracts waive preauthorization for involuntary commitment to a state hospital for mental health treatment. The examiners noted 22 contracts that did not include this waiver. 90.4% compliance. See Appendix V.

  Subsequent Event: FCHP revised contract language to accurately reflect the requirement of RCW 48.44.342. Costco new and renewing group contracts were revised September 1, 2001, standard large groups on December 1, 2001 and standard small groups on January 1, 2002.

- RCW 48.44.460 and WAC 284-44-042(1) require that optional coverage for Temporomandibular Joint (TMJ) Disorders must be offered. Two (2) contracts did not mention TMJ under Oral/Dental Care. However, it was stated in the Benefits and Exclusions that there was a separate lifetime limit for TMJ. These contracts also had exclusions for TMJ under the Limitations and Exclusions. 99.1% compliance. See Appendix VI.

- WAC 284-44-042(4)(a) and (4)(b) require contracts to include the definitions of "Temporomandibular Joint (TMJ) Disorders" and "Medical Services" for TMJ. The examiners noted 22 contracts that did not include the word "disease" in the definition as required. 90.4% compliance. See Appendix VII.

  Subsequent Event: FCHP revised contract language to accurately reflect the requirement of RCW 48.44.342. Costco new and renewing group contracts were revised September 1, 2001, standard large groups on December 1, 2001 and standard small groups on January 1, 2002.

- WAC 284-43-250(3)(b) requires that all participating providers be paid at the highest level of benefits. Twenty-six (26) contracts stated that a women's health care provider "…must be a Community Network Provider. Otherwise, care is covered at the extended or out-of-network level." 89.1% compliance. See Appendix VIII.

Subsequent Event: FCHP revised contract language in its Benefit Summaries. Changes were made to Boeing groups effective July 1, 2001, Costco new and renewing groups on September 1, 2001, standard large groups on December 1, 2001 and standard small groups on January 1, 2002.

- WAC 284-44-030(1) requires that every contract issued or renewed after December 31, 1974 conform to prescribed format standards. Sixty (60) contract forms contained footnotes at the end of pages in a much smaller font size than the rest of the text. 73.9% compliance. See Appendix IX.

PROVIDER CONTRACTS

First Choice Health Plan has traditionally contracted with provider organizations that in turn contract with individual hospitals, PCPs, specialists, and ancillary providers. Since January 2000, the Company has started contracting directly with many of the individual providers because many of the provider organizations have gone out of business.

Provider Contract Forms

The company provided the examiners with two generic provider contract forms. During the examination process, the examiners found eight (8) additional forms when reviewing individual contract files. As of November 30, 2000, the Company contracted with 250 individual providers and 22 provider networks. The provider networks maintained their own contracts with the providers working within each respective network. From the Inland Health Provider Directory dated August 2000 and the Service Area Provider Directory dated October 1999, the examiners randomly selected 43 individual contracts to review.

Findings

The Company passed the following Provider Contract Standards without comment:

Standard	Reference
Provider Contract Standard #2: The definition of emergency medical condition in a provider contract must comply with required definitions.	RCW 48.43.005(10), WAC 284-43-130(3)

The following exceptions were noted:

Provider Contract Standard #1: All provider contract forms must be filed and approved by the Office of the Insurance Commissioner prior to use. All provider contract forms must contain and adhere to the prescribed standards. Reference: RCW 48.44.070, WAC 284-43-320 through WAC 284-43-340.

Findings: Failed. 20% compliance. See Appendix X.

During the review of the materials provided, the examiners found eight (8) unfiled contract forms in use during the examination period. The Company has acknowledged that staffing issues prior to September 1999 resulted in provider contracts not being filed as required by Washington law. Provider contract forms are now filed timely and as required. FCHP informed the examiners that the providers at renewal of each contract are signing new and filed forms.

Provider Manuals

The examiners reviewed provider manuals for January 1999, February 2000, and October 2000. The Company rewrote the provider manual in July 2001. This version contains updated information in order to reflect updated Company policies and procedures.

CLAIMS

Procedures and Processes

The Company provided the examiners with a copy of its claims processing training and procedures manual. The examiners found the manual to be very extensive and detailed. It is updated as necessary. FCHP provided the examiners with updates that were not with the original materials received for review.

During the examination, the Company had contracts with four (4) provider organizations to process claims from members enrolled in those networks. These networks assumed all risk except prescription drugs, mental health/chemical dependency and vision. The provider organizations furnish FCHP with claims information via tape weekly. The examiners noted a steady decline in the number of claims being processed by the provider organizations during the examination period. Company personnel stated that one (1) group ceased claims processing as of December 31, 1999. FCHP took the claims processing back from two (2) of the groups in 2000. Only one (1) group continues to be delegated for claims processing.

Claim Review

The Company received 755,903 claims during the examination period. The breakdown of these claims is as follows:

- FCHP 722,182
- Pacific Medical Center 14,779
- Stevens Health Network 10,658
- Memorial Clinic 4,177
- Swedish Partners Medical Group 4,107

Because of the number of claims available in the total population, the examiners requested that the Company randomly select the claim files to be reviewed. The examiners asked the Company to randomly select a total of 300 claims. The Company provided the examiners with a sample of 323 claims. FCHP selected the claims using a skip interval formula. A random number was selected, and the sample was generated by sequentially going through the total population of claims.

Findings

The following exceptions were noted:

Claims Standard #1: The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.

Findings: Passed with comment. 99.4% compliance. See Appendix XI.

The Company had two (2) errors in the processing of claims involving coordination of benefits:

- On one (1) claim, the examiners noted that a higher amount should have been paid to the provider. FCHP's COB specialist told the examiners that the error occurred because the largest line item of the claim must be input first in order for the COB calculations to process correctly. The COB specialist indicated that this error was to be corrected and that special attention will be given to future COB claims involving more than one line item.
- FCHP paid too much to the provider as the secondary carrier on one (1) claim.

Claims Standard #2: The Company shall pay or deny 95% of all claims within 60 days of receipt (effective July 1, 2000). Reference: WAC 284-43-321(2)(a)(ii).

Findings: Passed.

WAC 284-43-321(2)(a)(ii) requires that 95% of all claims be paid within 60 days of receipt. If not paid in this time frame, the company must pay interest as well as the allowed payment amount. This was effective July 1, 2000. As part of the claim review process, the examiners tracked turn around time on claim payments. Of the 82 claims received after July 1, 2000, 80 were paid in 30 days or less, and two (2) were paid within 60 days of receipt.

The Company stated that since implementation of WAC 284-43-321(2)(a)(ii), they paid $13,465.37 in interest on claims held more than 60 days through September 2001.

Additional Comments

The examiners found errors on four (4) of the 323 claims that fell into the following categories:

Type of Error	# of Errors
Claim Input	1
Claim Processing	3
Total	**4**

One (1) claim had data entry input errors. This claim had a notation that other coverage was involved and that COB should be processed. The member had no other coverage.

Three (3) claims were processed incorrectly:

- One (1) claim had two dates of service on the form. A copayment was taken for one of the dates, but not for the other.
- One (1) claim was for radiology services in conjunction with a women's direct access visit. It was denied for no authorization when an authorization was not required.
- One (1) claim had a related claim that occurred on the same date. One (1) claim was for the facility charge, and the other claim was for the professional services. The professional services claim was denied in error by the claims processor.

The Company informed the examiners that all errors were immediately corrected upon discovery. In addition, FCHP implemented a consistent 5% random audit for all processors in April 2000. Audit statistics identify processor, training, and documentation issues for which policies and procedures are drafted and implemented. The audit procedure is as follows:

- Unposted claims are pulled.
- Five (5) percent of the claims are randomly selected.
- The claim data is downloaded to an Access database that screens for errors.
- The audit process screens every data entry field of the claims system for errors.

The examiners were provided with copies of the audit screens used for both professional claims and hospital claims. The screens are comprehensive. Based on the number of errors identified during our review, the audit measure proves to be an effective tool in alleviating processing errors.

INSTRUCTIONS

	INSTRUCTIONS	PAGE #
1	The Company is instructed to respond to appeals within 14 days as required by WAC 284-43-620.	12
2	The Company is instructed to ensure that agents are properly licensed and appointed prior to allowing them to solicit business on behalf of the Company in order to comply with RCW 48.44.011 and RCW 48.17.060(1) and (2).	13
3	The Company is instructed to file its rates and benefits in their entirety with the OIC prior to use as required by RCW 48.44.040 and WAC 284-43-920(1).	14
4	The Company is instructed to refund premiums that were charged to groups in excess of the filed rates pursuant to RCW 48.44.040 and WAC 284-43-920(1).	15
5	The Company is instructed to file the negotiated plan rates and benefits for those groups that were not filed pursuant to RCW 48.44.040 and WAC 284-43-920(1).	15
6	The Company is instructed to include all mandated benefit provisions in its contracts as required by Chapters 48.43 and 48.44 RCW, and Chapters 284-43, 284-44, 284-51, 284-52, and 284-53 WAC.	17
7	The Company is instructed to file all provider contract forms with the OIC prior to use as required by RCW 48.44.070 and WAC 284-43-330(1).	18

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	It is recommended that the Company cite sources of statistical data in its advertising materials to comply with WAC 284-50-110(3).	9
2	The Company is instructed to respond to communication from the OIC within 15 business days of receipt of correspondence to assure compliance with WAC 284-30-650.	12
3	It is recommended that the referral and preauthorization procedure in member materials be located in one section rather than parts in multiple locations in the materials. In addition, further education and monitoring of the providers is required in order to alleviate errors and misunderstandings in the preauthorization and referral process.	16
3	It is recommended that the Company consistently audit claims involving Coordination of Benefits to assure correct data entry and processing as prescribed in WAC 284-51.	20

FIRST CHOICE HEALTH PLAN
SUMMARY OF STANDARDS
MARKET CONDUCT EXAMINATION
JUNE 1, 1999 TO NOVEMBER 30, 2000

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The Company is required to be registered with the Office of the Insurance Commissioner prior to acting as a health care service contractor in the State of Washington. (RCW 48.44.015(1))	8	X	
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, ByLaws, and amendments at the same time as submitting such documents to the Secretary of State. (RCW 48.44.013)	8	X	

Advertising:

#	STANDARD	PAGE	PASS	FAIL
1	The Company's advertising materials are published and maintained in accordance with all Washington Advertising Regulations. (RCW 48.30.040 through RCW 48.30.090, RCW 48.44.110, and WAC 284-50-010 through WAC 284-50-230)	9	X	

Complaints:

#	STANDARD	PAGE	PASS	FAIL
1	The Company has filed a copy of its procedure for review and adjudication of complaints with the OIC. (RCW 48.43.055)	12	X	
2	The Company has a means to disclose to an enrollee or prospective enrollee a copy of the grievance procedures for claims and for service denials as well as dissatisfaction with care. (RCW 48.43.095(1)(h)) ***Effective until July 1, 2001.***	12	X	
3	The Company complies with procedures for health care service review decisions. (WAC 284-43-620) ***Effective December 30, 1999.***	12		X
4	Response to communication from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested in the original communication. (WAC 284-30-650, Technical Advisory T98-4)	12	X	

Agent Activity:

#	STANDARD	PAGE	PASS	FAIL
1	The Company ensures that agents are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. (RCW 48.44.011, RCW 48.17.060(1) and (2))	13		X
2	The Company requires that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. (RCW 48.17.010)	13	X	

Sales Activity, Rates, Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms and all rates have been filed with the Office of Insurance Commissioner prior to use. (RCW 48.44.040, WAC 284-43-920(1))	14		X

Contracts and Member Handbooks:

#	STANDARD	PAGE	PASS	FAIL
1	All contracts must contain mandated benefit provisions and conform to prescribed format standards. (Chapters 48.43 and 48.44 RCW, and Chapters 284-43, 284-44, 284-51, 284-52, and 284-53 WAC)	17		X

Provider Contracts:

#	STANDARD	PAGE	PASS	FAIL
1	All provider contract forms must be filed and approved by the OIC prior to use. All provider contract forms must contain and adhere to the prescribed standards. (RCW 48.44.070, WAC 284-43-330 through WAC 284-43-340)	18		X
4	The definition of emergency medical condition in a provider contract must comply with required definitions. (RCW 48.43.005(10), WAC 284-43-130(3))	18	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The Company administers Coordination of Benefits provisions as required. (Chapter 284-51 WAC)	20	X	
2	The Company shall pay or deny 95% of all claims within 60 days of receipt. (WAC 284-43-321(2)(a)(ii)) ***Effective 7/1/00.***	20	X	

APPENDIX I
Complaint Standard #3
The Company must reconsider adverse determination within 14 days.
WAC 284-43-620(1)

OIC ID #	FCHP ID #	# OF DAYS
12	123	36
17	188	85

APPENDIX II
Complaint Standard #4
The Company shall respond to the OIC within 15 business days.
WAC 284-30-650

OIC ID #	FCHP ID #	# OF DAYS
15	35	37
28	26	19

APPENDIX III
Agent Activity Standard #1
Agents Not Licensed or Appointed by the Company
RCW 48.17.060(1) and (2), RCW 48.44.011

Sold Cases:

Agent Name	License Date	Appointment Date	Group Effective Date
Agent #1	5/4/99	5/4/99	1/1/99

Quotes:

Agent Name	License Date	Appointment Date	Quote Date
Agent #2			11/1/00
Agent #3			11/1/00

APPENDIX IV
Sales Activity Standard #1
Rates and Benefits Quoted Have Been Filed with the OIC
RCW 48.44.040 and WAC 284-43-920(1)

OIC ID #	GROUP #	OVERCHARGED	UNDERCHARGED	UNFILED NEGOTIATED GROUPS
5	STSO			X
6	STCB			X
8	8C			X
9	76		X	
12	135			X
13	49		X	
14	2B	X (COBRA Rates)		
18	2	X (COBRA Rates)		
29	111			X
39	208	X		
40	210G			X (Mgd)
40	210G			X (POS)
46	ABC307		X	
53	E222	X		
54	E237	X		
70	E76	X		
74	E856		X (1999)	
74	E856		X (2000)	

APPENDIX V
Contracts and Member Handbooks Standard #1
Contracts May Not Require Preauthorization for Involuntary Commitment to a Mental Health Facility
RCW 48.44.342

Form Number	Description	Effective Date
CERT.BAS.0896	FCHP Certificate of Member Coverage – Basic Plan	01-01-96
CERT.STD(FCHP).0199	FCHP Certificate of Member Coverage – Managed Care Plan	01-01-99
CERT.POS(FCHP).0199	FCHP Certificate of Member Coverage – Point Of Service Plan	01-01-99
CERT.OPT(FCHP).0199	FCHP Certificate of Member Coverage – Triple Option Plan	01-01-99
CERT.OOA-75(FCHP).0199	FCHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-99
CERT. OOA-80(FCHP).0199	FCHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-99
CERT.STD(IHP).1298	IHP Certificate of Member Coverage – Managed Care Plan	01-01-99
CERT.POS(IHP). 1298	IHP Certificate of Member Coverage – Point Of Service Plan	01-01-99
CERT.OPT(IHP). 1298	IHP Certificate of Member Coverage – Triple Option Plan	01-01-99
CERT.OOA-75(IHP). 1298	IHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-99
CERT. OOA-80(IHP). 1298	IHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-99
CERT.BAS.0100	FCHP Certificate of Member Coverage – Basic Plan	01-01-00
CERT.MGD[FCHP].0100	FCHP Certificate of Member Coverage – Managed Care Plan	01-01-00
CERT.POS[FCHP].0100	FCHP Certificate of Member Coverage – Point Of Service Plan	01-01-00
CERT.OPT[FCHP].0100	FCHP Certificate of Member Coverage – Triple Option Plan	01-01-00
CERT.OOA-75.0100	FCHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-00

Form Number	Description	Effective Date
CERT.OOA-80.0100	FCHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-00
CERT.MGD[IHP].0100	IHP Certificate of Member Coverage – Managed Care Plan	01-01-00
CERT.POS[IHP].0100	IHP Certificate of Member Coverage – Point Of Service Plan	01-01-00
CERT.OPT[IHP].0100	IHP Certificate of Member Coverage – Triple Option Plan	01-01-00
CERT.OOA-75(IHP).0100	IHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-00
CERT. OOA-80(IHP).0100	IHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-00

APPENDIX VI
Contracts and Member Handbooks Standard #1
TMJ Coverage Must be Offered
RCW 48.44.460 and WAC 284-44-042(1)

Form Number	Description	Effective Date
CERT.BAS.0896	FCHP Certificate of Member Coverage – Basic Plan	01-01-96
CERT.BAS.0100	FCHP Certificate of Member Coverage – Basic Plan	01-01-00

APPENDIX VII
Contracts and Members Handbooks Standard #1
TMJ Definition to be Included
WAC 284-44-042(4)(a)-(b)

Form Number	Description	Effective Date
CERT.BAS.0896	FCHP Certificate of Member Coverage – Basic Plan	01-01-96
CERT.STD(FCHP).0199	FCHP Certificate of Member Coverage – Managed Care Plan	01-01-99
CERT.POS(FCHP).0199	FCHP Certificate of Member Coverage – Point Of Service Plan	01-01-99
CERT.OPT(FCHP).0199	FCHP Certificate of Member Coverage – Triple Option Plan	01-01-99
CERT.OOA-75(FCHP).0199	FCHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-99
CERT. OOA-80(FCHP).0199	FCHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-99
CERT.STD(IHP). 1298	IHP Certificate of Member Coverage – Managed Care Plan	01-01-99
CERT.POS(IHP). 1298	IHP Certificate of Member Coverage – Point Of Service Plan	01-01-99
CERT.OPT(IHP). 1298	IHP Certificate of Member Coverage – Triple Option Plan	01-01-99
CERT.OOA-75(IHP). 1298	IHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-99
CERT. OOA-80(IHP). 1298	IHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-99
CERT.BAS.0100	FCHP Certificate of Member Coverage – Basic Plan	01-01-00
CERT.MGD[FCHP].0100	FCHP Certificate of Member Coverage – Managed Care Plan	01-01-00
CERT.POS[FCHP].0100	FCHP Certificate of Member Coverage – Point Of Service Plan	01-01-00
CERT.OPT[FCHP].0100	FCHP Certificate of Member Coverage – Triple Option Plan	01-01-00
CERT.OOA-75.0100	FCHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-00
CERT.OOA-80.0100	FCHP Certificate of Member Coverage – 80/100 – Out Of Area	01-01-00

Form Number	Description	Effective Date
	Plan	
CERT.MGD[IHP].0100	IHP Certificate of Member Coverage – Managed Care Plan	01-01-00
CERT.POS[IHP].0100	IHP Certificate of Member Coverage – Point Of Service Plan	01-01-00
CERT.OPT[IHP].0100	IHP Certificate of Member Coverage – Triple Option Plan	01-01-00
CERT.OOA-75(IHP).0100	IHP Certificate of Member Coverage – 75/250 – Out Of Area Plan	01-01-00
CERT. OOA-80(IHP).0100	IHP Certificate of Member Coverage – 80/100 – Out Of Area Plan	01-01-00

APPENDIX VIII
Contracts and Member Handbooks Standard #2
Women's Direct Access Requirements Must be Met
WAC 284-43-250

Form Number	Description	Effective Date
CERT.STD(FCHP).0199	FCHP Certificate of Member Coverage – Managed Care Plan	01-01-99
Mbr.STD (FCHP).0199	FCHP Member Handbook – Managed Care Plan	01-01-99
CERT.POS(FCHP).0199	FCHP Certificate of Member Coverage – Point Of Service Plan	01-01-99
Mbr.POS(FCHP).0199	FCHP Member Handbook – Point Of Service Plan	01-01-99
CERT.OPT(FCHP).0199	FCHP Certificate of Member Coverage – Triple Option Plan	01-01-99
Mbr.OPT(FCHP).0199	FCHP Member Handbook – Triple Option Plan	01-01-99
CERT.STD(IHP). 1298	IHP Certificate of Member Coverage – Managed Care Plan	01-01-99
Mbr.STD(IHP). 1298	IHP Member Handbook – Managed Care Plan	01-01-99
CERT.POS(IHP). 1298	IHP Certificate of Member Coverage – Point Of Service Plan	01-01-99
Mbr.POS(IHP). 1298	IHP Member Handbook – Point Of Service Plan	01-01-99
CERT.OPT(IHP). 1298	IHP Certificate of Member Coverage – Triple Option Plan	01-01-99
Mbr.OPT (IHP). 1298	IHP Member Handbook – Triple Option Plan	01-01-99
CERT.BAS.0100	FCHP Certificate of Member Coverage – Basic Plan	01-01-00
CERT.MGD[FCHP].0100	FCHP Certificate of Member Coverage – Managed Care Plan	01-01-00
Mbr.MGD[FCHP].0100	FCHP Member Handbook – Managed Care Plan	01-01-00
CERT.POS[FCHP].0100	FCHP Certificate of Member Coverage – Point Of Service Plan	01-01-00
Mbr.POS[FCHP].0100	FCHP Member Handbook – Point Of Service Plan	01-01-00
CERT.OPT[FCHP].0100	FCHP Certificate of Member Coverage – Triple Option Plan	01-01-00

Form Number	Description	Effective Date
Mbr.OPT[FCHP].0100	FCHP Member Handbook – Triple Option Plan	01-01-00
CERT.MGD[IHP].0100	IHP Certificate of Member Coverage – Managed Care Plan	01-01-00
Mbr.MGD[IHP].0100	IHP Member Handbook – Managed Care Plan	01-01-00
CERT.POS[IHP].0100	IHP Certificate of Member Coverage – Point Of Service Plan	01-01-00
Mbr.POS[IHP].0100	IHP Member Handbook – Point Of Service Plan	01-01-00
CERT.OPT[IHP].0100	IHP Certificate of Member Coverage – Triple Option Plan	01-01-00
Mbr.OPT[IHP].0100	IHP Member Handbook – Triple Option Plan	01-01-00

APPENDIX IX
Contracts and Member Handbooks Standard #4
Text Size Must be Uniform throughout the Contract
WAC 284-44-030(1)

Form Number	Description	Effective Date
10-0-MGD(FCHP).0199	FCHP Benefits Summary – 10/0 Managed Care Plan	01-01-99
10-100-MGD(FCHP).0199	FCHP Benefits Summary – 10/100 Managed Care Plan	01-01-99
10-200-MGD(FCHP).0199	FCHP Benefits Summary – 10/200 Managed Care Plan	01-01-99
15-200-MGD(FCHP).0199	FCHP Benefits Summary – 15/200 Managed Care Plan	01-01-99
20-200-MGD(FCHP).0199	FCHP Benefits Summary – 20/200 Managed Care Plan	01-01-99
10-0-POS(FCHP).0199	FCHP Benefits Summary – 10/0 Point Of Service Plan	01-01-99
10-200-POS(FCHP).0199	FCHP Benefits Summary – 10/200 Point Of Service Plan	01-01-99
10-200-POS(A)(FCHP).0199	FCHP Benefits Summary – 10/200A Point Of Service Plan	01-01-99
15-0-POS(FCHP).0199	FCHP Benefits Summary – 15/0 Point Of Service Plan	01-01-99
15-100-POS(FCHP).0199	FCHP Benefits Summary – 15/100 Point Of Service Plan	01-01-99
15-200-POS(FCHP).0199	FCHP Benefits Summary – 15/200 Point Of Service Plan	01-01-99
20-200-POS(FCHP).0199	FCHP Benefits Summary – 20/200 Point Of Service Plan	01-01-99
100-70-50-OPT(FCHP).0199	FCHP Benefits Summary – 100/70/50 – Triple Option Plan	01-01-99
100-80-60-OPT(FCHP).0199	FCHP Benefits Summary – 100/80/60 – Triple Option Plan	01-01-99
10-0-MGD(IHP).1298	IHP Benefits Summary – 10/0 Managed Care Plan	01-01-99
10-100-MGD(IHP).1298	IHP Benefits Summary – 10/100 Managed Care Plan	01-01-99
10-200-MGD(IHP).1298	IHP Benefits Summary – 10/200 Managed Care Plan	01-01-99
15-200-MGD(IHP).1298	IHP Benefits Summary – 15/200 Managed Care Plan	01-01-99

Form Number	Description	Effective Date
20-200-MGD(IHP).1298	IHP Benefits Summary – 20/200 Managed Care Plan	01-01-99
10-0-POS(IHP).1298	IHP Benefits Summary – 10/0 Point Of Service Plan	01-01-99
10-100-POS(IHP).1298	IHP Benefits Summary – 10/100 Point Of Service Plan	01-01-99
10-200-POS(IHP).1298	IHP Benefits Summary – 10/200 Point Of Service Plan	01-01-99
10-200-POS(A)(IHP).1298	IHP Benefits Summary – 10/200A Point Of Service Plan	01-01-99
15-0-POS(IHP).1298	IHP Benefits Summary – 15/0 Point Of Service Plan	01-01-99
15-100-POS(IHP).1298	IHP Benefits Summary – 15/100 Point Of Service Plan	01-01-99
15-200-POS(IHP).1298	IHP Benefits Summary – 15/200 Point Of Service Plan	01-01-99
20-200-POS(IHP).1298	IHP Benefits Summary – 20/200 Point Of Service Plan	01-01-99
100-70-50-OPT(IHP).0199	IHP Benefits Summary – 100/70/50 – Triple Option Plan	01-01-99
100-80-60-OPT(IHP).0199	IHP Benefits Summary – 100/80/60 – Triple Option Plan	01-01-99
BAS.BEN.0100	FCHP Benefits Summary – Basic Plan	01-01-00
10-0-MGD[FCHP].0100	FCHP Benefits Summary – 10/0 Managed Care Plan	01-01-00
10-100-MGD[FCHP].0100	FCHP Benefits Summary – 10/100 Managed Care Plan	01-01-00
10-200-MGD[FCHP].0100	FCHP Benefits Summary – 10/200 Managed Care Plan	01-01-00
15-200-MGD[FCHP].0100	FCHP Benefits Summary – 15/200 Managed Care Plan	01-01-00
20-200-MGD[FCHP].0100	FCHP Benefits Summary – 20/200 Managed Care Plan	01-01-00
10-0-POS[FCHP].0100	FCHP Benefits Summary – 10/0 Point Of Service Plan	01-01-00
10-100-POS[FCHP].0100	FCHP Benefits Summary – 10/100 Point Of Service Plan	01-01-00
10-200-POS[FCHP].0100	FCHP Benefits Summary – 10/200 Point Of Service Plan	01-01-00
10-200-POS(A)[FCHP].0100	FCHP Benefits Summary – 10/200A Point Of Service Plan	01-01-00

Form Number	Description	Effective Date
15-0-POS[FCHP].0100	FCHP Benefits Summary – 15/0 Point Of Service Plan	01-01-00
15-100-POS[FCHP].0100	FCHP Benefits Summary – 15/100 Point Of Service Plan	01-01-00
15-200-POS[FCHP].0100	FCHP Benefits Summary – 15/200 Point Of Service Plan	01-01-00
20-200-POS[FCHP].0100	FCHP Benefits Summary – 20/200 Point Of Service Plan	01-01-00
100-70-50-OPT[FCHP].0100	FCHP Benefits Summary – 100/70/50 – Triple Option Plan	01-01-00
100-80-60-OPT[FCHP].0100	FCHP Benefits Summary – 100/80/60 – Triple Option Plan	01-01-00
10-0-MGD[IHP].0100	IHP Benefits Summary – 10/0 Managed Care Plan	01-01-00
10-100-MGD[IHP].0100	IHP Benefits Summary – 10/100 Managed Care Plan	01-01-00
10-200-MGD[IHP].0100	IHP Benefits Summary – 10/200 Managed Care Plan	01-01-00
15-200-MGD[IHP].0100	IHP Benefits Summary – 15/200 Managed Care Plan	01-01-00
20-200-MGD[IHP].0100	IHP Benefits Summary – 20/200 Managed Care Plan	01-01-00
10-0-POS[IHP].0100	IHP Benefits Summary – 10/0 Point Of Service Plan	01-01-00
10-100-POS[IHP].0100	IHP Benefits Summary – 10/100 Point Of Service Plan	01-01-00
10-200-POS[IHP].0100	IHP Benefits Summary – 10/200 Point Of Service Plan	01-01-00
10-200-POS(A)[IHP].0100	IHP Benefits Summary – 10/200A Point Of Service Plan	01-01-00
15-0-POS[IHP].0100	IHP Benefits Summary – 15/0 Point Of Service Plan	01-01-00
15-100-POS[IHP].0100	IHP Benefits Summary – 15/100 Point Of Service Plan	01-01-00
15-200-POS[IHP].0100	IHP Benefits Summary – 15/200 Point Of Service Plan	01-01-00
20-200-POS[IHP].0100	IHP Benefits Summary – 20/200 Point Of Service Plan	01-01-00
100-70-50-OPT[IHP].0100	IHP Benefits Summary – 100/70/50 – Triple Option Plan	01-01-00
100-80-60-OPT(IHP).0100	IHP Benefits Summary – 100/80/60 – Triple Option Plan	01-01-00

APPENDIX X
Provider Contracts Standard #3
Provider Contracts Must be Filed
RCW 48.44.070, WAC 284-43-330(1)

OIC ID #	FORM NUMBER	DESCRIPTION
S-1, S-2, S-3	client\fch\FCHPk.doc	Provider Service Agreement
S-4, S-5, S-9, S-10, S-12, S-14, S-20, S-21, S-25, S-26, S-38, S-39, S-42	No form number	Standard PO Service Agreement
S-6	No form number	Agreement for Provision of Mental Health and/or Substance Abuse Services
S-7, S-8, S-22, S-43	No form number	Standard Provider Organization Service Agreement
S-8, S-11	No form number	Health Care Facility Agreement
S-13, S-14, S-15, S-16, S-17, S-18, S-19, S-23, S-24, S-29, S-30, S-31, S-32, S-33, S-36, S-40, S-41	PO_CR_01	Standard Non-Delegated Claims PO Service Agreement
S-27, S-28	No form number	Health Plan and Medical Group Services Agreement
S-34, S-35, S-37	PO_DC_01	Standard Delegated Claims PO Service Agreement

APPENDIX XI
Claims Standard #1
The Company Correctly Administers Coordination of Benefits
Chapter 284-51 WAC

Claim #	Type of Error	Comments
1488453	COB Processing	FCHP paid too much to the provider.
2322843	COB Processing	Largest line item must be entered first in order for system to calculate COB correctly.